The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Chief Executive Officer
Maureen G. Phipps, MD, MPH, FACOG

March 28, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Box 8016, Baltimore, MD 21244-8016

RE: Missouri Targeted Benefits for Pregnant Women Demonstration

Dear Administrator Verma:

The American College of Obstetricians and Gynecologists (ACOG) represents more than 60,000 obstetrician-gynecologists and partners in women's health nationwide, including more than 700 practicing obstetrician-gynecologists in its Missouri Section. ACOG welcomes the opportunity to comment on the Missouri Department of Social Services' Targeted Benefits for Pregnant Women Demonstration proposal. As physicians dedicated to providing quality care to women, ACOG recognizes that continuous access to Medicaid is crucial to addressing our nation's rising rates of maternal mortality and severe maternal morbidity. While ACOG believes all women with a Medicaid-covered birth should be eligible for at least 12 months of continuous coverage after the end of pregnancy, we applaud Missouri's unique approach to covering women with substance use disorder for an additional twelve months beyond the current standard of 60 days postpartum. We urge the Centers for Medicare and Medicaid Services (CMS) to act quickly and approve this waiver.

According to the Centers for Disease Control and Prevention (CDC), more than 900 pregnancy-related deaths occurred in the U.S. in 2018.[1*] Missouri has not been immune to this crisis – in fact, maternal mortality rates in Missouri represent some of the highest in the nation.[2] Between 2013 and 2018, there were 165 maternal deaths in the state.[3] Notably, black residents of Missouri have nearly three times the maternal mortality rate of white residents (91.9 per 100,000 versus 32.9 per 100,000 respectively).[4]

Maternal deaths related to substance use disorder are often preceded by comorbid mental health disorders that could be identified and treated with appropriate health care coverage. Pregnant women with opioid use disorder often suffer from co-occurring mental health conditions, particularly depression, history of trauma, posttraumatic stress disorder, and anxiety.[5] In fact, more than 30 percent of pregnant women enrolled in a substance use treatment program screened positive for moderate to severe depression, and more than 40 percent reported symptoms of postpartum depression.[6] Pregnant and postpartum who use opioids are also at increased risk of use of other substances, including tobacco, marijuana, and cocaine.[7] These patients also often suffer from poor nutrition and many have disrupted support systems leading to increased social service needs.[8]

Under current law, women who are eligible for Medicaid based on their pregnancy become ineligible 60 days after the end of pregnancy.[9] While some women are able to successfully transition to other sources

[*] This calculation excludes deaths that are pregnancy-associated, such as those due to opioids and suicide, and deaths to women over the age of 44.

of coverage at this time, many are left in the untenable position of being uninsured shortly after a major medical event.[10,11] The timing of maternal deaths related to substance use disorder underscores the importance of continued access to health insurance in the later postpartum period. Deaths related to overdose and suicide are now the leading cause of maternal mortality in a growing number of states.[12,13,14,15,16,17] Importantly, 75 percent of these deaths occur more than 43 days after the end of pregnancy, and women with substance use disorder are more likely to experience relapse and overdose 7-12 months postpartum.[18,19,20] According to ACOG Committee Opinion No. 711 "Opioid Use and Opioid Use Disorder in Pregnancy," triggers for relapse may include loss of insurance and access to treatment.[21]

Missouri's proposed coverage extension – though limited – will better ensure the health of mothers and infants is preserved by allowing women uninterrupted access to mental health providers and pharmacotherapy or other treatment for substance use disorder.

Not only is this policy routed in clinical evidence, but it's also likely to save money for both the state and the federal government. According to a March 2014 report from the Medicaid and CHIP Payment and Access Commission (MACPAC), reducing churn in the Medicaid program lowers monthly per capita spending.[22] In addition, keeping women in the system presents the opportunity to address any ongoing health concerns, including those unrelated to pregnancy, before any subsequent pregnancies. This is especially important for women on Medicaid who are more likely to have had a prior preterm birth, low birthweight baby, and experience certain chronic conditions, like substance use disorder.[23] Addressing these concerns will help avoid long-term costs due to untreated conditions that may impact future pregnancies.

Moreover, unintended pregnancy rates among women with substance use disorder are approximately 80 percent.[24] This is considerably higher than the rate in the general population. Use of reliable contraception is also lower among this group of women when compared with a nondrug-using comparison population.[25] Given these statistics, ACOG is pleased that women who are eligible for this postpartum coverage extension will also be eligible for family planning services and supplies under the Medicaid Extended Women's Program for Uninsured Women. Reducing unplanned pregnancies for this population and averting potential neonatal intensive care unit (NICU) admissions for infants born with neonatal abstinence syndrome (NAS) could save the health care system millions of dollars.[26]

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Thank you for the opportunity to provide comments on the Missouri Department of Social Services' Targeted Benefits for Pregnant Women Demonstration proposal. We hope you have found our comments useful. To discuss these recommendations further, please contact Emily Eckert, Senior Health Policy Analyst, at eeckert@acog.org or 202-863-2485.

Sincerely,

Maureen G. Phipps, MD, MPH, FACOG
Chief Executive Officer

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